

**WEST HARTFORD  
HUMAN & LEISURE SERVICES**

Dear Families:

We are thrilled that you have chosen to register your child for **Beachland Adventures 2016**. We're already hard at work planning fun and engaging summer activities for your child including splashing in the newly renovated Beachland Park pool and bathhouse!

Here is a list of forms which need to be completed and returned by **Friday, June 10<sup>th</sup>**:

- Camp Information Sheet - Participant Profile, 2016
- Camper Health Form
- Epi Pen Form (if necessary)
- Administration of "Over the Counter" Medications Form
- Administration of Prescription Medications Form (if necessary)
- Parent Swimming Assessment, 2016
- Pick-Up Authorization, 2016
- Photo Permission Slip 2016
- Behavioral Compliance Statement (2 copies – return one and keep one)
- West Hartford Leisure Services Safety & Emergency Contact Form
- A recent photo of your child

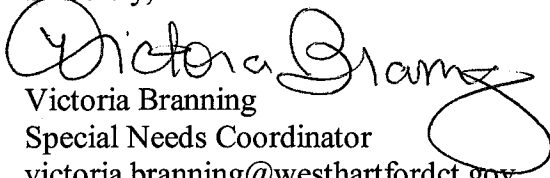
Please mail or deliver the completed documents to the Elmwood Community Center main office: Special Needs Coordinator, Elmwood Community Center, 1106 New Britain Avenue, West Hartford, CT 06110. Campers **WILL NOT** be able to attend camp until we have received these forms and they have been reviewed by the camp nurse.

Campers should bring a lunch/snack, towel & swimsuit, change of clothes, sunscreen, water bottle and a hat/sunglasses to camp every day. Please label all items with your child's name. The Special Needs Program is not responsible for items that are lost or stolen.

If your child is attending Town of West Hartford Extended School Year (summer school), please make the Transportation Office (860-561-6647) aware that you would like your child transported from their ESY location to Beachland Park for summer camp. It takes a minimum of a week for the transportation office to implement changes, so it's critical that you let them know the weeks your child will be attending camp as soon as possible.

Our staff is excited to share this summer's adventures with you and your child!

Sincerely,

  
Victoria Branning  
Special Needs Coordinator  
victoria.branning@westhartfordct.gov  
860-561-8173



**TOWN OF WEST HARTFORD**  
SPECIAL NEEDS PROGRAM 1106 NEW BRITAIN AVENUE  
WEST HARTFORD, CONNECTICUT 06110-2233  
(860) 561-8173 FAX: (860) 561-8161

[www.westhartford.org](http://www.westhartford.org)

*An Equal Opportunity/Affirmative Action Employer*

**Town of West Hartford**  
**Department of Human & Leisure Services**  
**Special Needs Program**

**Beachland Adventures - Participant Profile**  
**2016**

Camper Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Nickname (if preferred) \_\_\_\_\_ Grade in Fall: \_\_\_\_\_ School: \_\_\_\_\_

Street Address \_\_\_\_\_

Town \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email (H) \_\_\_\_\_ Email (W) \_\_\_\_\_

- Please include a current photo of your child with your completed paperwork

**In the event of an emergency and the parent/guardian cannot be reached,  
please contact the following individual(s):**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

**YOU MUST NAME SOMEONE WHO IS REACHABLE DURING ACTIVITY HOURS!**



Primary disability/impairment\_\_\_\_\_

Please indicate with a check if applicable:

_____Down Syndrome	_____Cerebral Palsy	_____Autism
_____Speech/Language Disorder	_____Visual Impairment	_____Impulsive
_____Hearing Impairment	_____Touch Sensitive	_____OCD
_____Orthopedic Challenges	_____Cognitive Delay	_____ADD/ADHD
_____Low Muscle Tone	_____Developmental Delay	_____Sign Language
_____Transition Difficulty	_____Social/Emotional Difficulty	_____Epilepsy
_____Self-Help Difficulty	_____PDD	_____Other

Please Explain Item(s) Checked Above:

---

---

---

Asthma?\_\_\_\_\_Yes \_\_\_\_\_No \*\* If yes, inhaler(s) MUST be provided DAILY and participant must be capable of self-administration under staff supervision. Inhaler remains in child's possession during day. Details, for example, triggers (exercise, pollen, mold):

---

---

Life-Threatening Allergy? \_\_\_\_\_Yes \_\_\_\_\_No If yes, to what?\_\_\_\_\_ \*\*Epi-Pen MUST be provided to activity leader and the following form MUST be completed: "Parent Authorization for the Department of Human & Leisure Services of the Town of West Hartford to Administer Epinephrine Injection" (Part I, completed by Parent; Part II, completed by Physician). This form is available at Dept. of Leisure Services Office, Town Hall, or at the Elmwood Community Center's main office. Phone requests may be made, 860-561-7510 (TH) or 860-561-8160 (ECC).

Medication(s)? \_\_\_\_\_ yes \_\_\_\_\_ no If yes, please list medications and any side effects of which staff should be aware.

---

---

Any restrictions at camp? (i.e. sun, heat, exercise, swimming, eating):

---

---

Any special needs during camp day? (i.e. physical assistance, rest periods, help in changing clothes, help with eating):

---

---

If participant is non-ambulatory, does he/she use a:

Wheelchair? ☐ Yes ☐ No Cane? ☐ Yes ☐ No

Crutches? ☐ Yes ☐ No Arm/leg Braces? ☐ Yes ☐ No

Guide dog? ☐ Yes ☐ No Walker? ☐ Yes ☐ No

\* If you answered YES to any of above, a conversation will take place with Special Needs Program staff prior to the start of camp to determine how best to meet your child's needs.

Does your child have a 1:1 aide at school? ☐ Yes ☐ No

Does your child share an aide at school? ☐ Yes ☐ No

Is your child in mainstream class? ☐ Yes ☐ No  
Approximately what percentage of academic day? \_\_\_\_\_

Is your child in alternative class or contained program? ☐ Yes ☐ No

Does your child receive support services at school? (PT, OT, Speech, etc) ☐ Yes ☐ No

Please explain: \_\_\_\_\_

---

**PLEASE PROVIDE INFORMATION REGARDING THE FOLLOWING:**

Fear(s), for example thunder, animals, loud noises, water, etc.:

---

---

What works best to calm/reassure participant in situations indicated above?

---

---

Communication skills (verbal, non-verbal, sign language, communication board, iPad or other assistive technology):

---

---

Personality (i.e. shy, friendly/out-going, temperamental, anxious, risk-taker, independent, hesitant, passive, quick to anger, distractible, etc.) and hints on how best to work with individual:

---

---

Eating/drinking limitations and/or habits:

---

---

Behavior patterns, transition suggestions, “triggers” that may lead to stress or anxiety, etc:\_\_\_\_\_

---

---

Interests/Hobbies/Talents:

---

---

---

Challenges with Fine Motor, Gross Motor and/or Self-Help Skills:

---

---

---

Please share any information not requested above which will be helpful to staff in providing a positive recreational experience:\_\_\_\_\_

---

---

---

**NOTE: FAMILIES ARE REQUIRED TO PROVIDE DIAPERS & ALL PERSONAL CARE ITEMS**  
.....

**COMPLETED BY:**

Parent/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (Cell) \_\_\_\_\_

*(Office Use Only)*

Date Received: \_\_\_\_\_



WEST HARTFORD HUMAN AND LEISURE SERVICES  
SPECIAL NEEDS PROGRAM— 2016

BEACHLAND ADVENTURES HEALTH FORM  
(Medical Examination Completed by MD, PA or APRN)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Street: \_\_\_\_\_

Town: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

CODE: S – Satisfactory

X – Not Satisfactory (Explain)

0 – Not Examined

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_ HGB \_\_\_\_\_ Urinalysis \_\_\_\_\_

Primary disability or impairment: \_\_\_\_\_

Eyes \_\_\_\_\_  
Glasses/Contacts \_\_\_\_\_  
Ears \_\_\_\_\_  
Nose \_\_\_\_\_  
Throat \_\_\_\_\_  
Teeth \_\_\_\_\_  
Heart \_\_\_\_\_  
Lungs \_\_\_\_\_  
Abdomen \_\_\_\_\_  
Hernia \_\_\_\_\_

Extremities \_\_\_\_\_  
Posture (spine) \_\_\_\_\_  
Skin \_\_\_\_\_  
Allergy: Please specify type of allergy as well as  
treatment (dosage) and method of delivery. Note if  
epi-pen is required. \* \_\_\_\_\_

\*An "Authorization for the Town of West Hartford, Department of Leisure Services to administer Epinephrine Injection" form must be on file at camp

**RECOMMENDATIONS AND RESTRICTIONS**

Diet \_\_\_\_\_  
Medication (Name) \_\_\_\_\_  
Swimming \_\_\_\_\_  
Strenuous Activity \_\_\_\_\_  
Other \_\_\_\_\_

**IMMUNIZATION HISTORY - Required immunizations must be determined locally.**

This is a record of dates of basic immunizations and most recent booster doses.

DTP Series _____	Booster _____	Tetanus Booster _____
Polio OPV (Sabin) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____		Tuberculin Test _____
German Measles (Rubella) _____		Mumps Vaccine (live) _____
Smallpox _____	Other _____	Other _____

I have examined the person herein described and have reviewed his or her health history. It is my opinion that he/she is physically able to participate in an outdoor camp program offered by the Town of West Hartford Department of Human and Leisure Services.

Examining Physician, PA or APRN \_\_\_\_\_

Telephone (Area Code and Number) \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Fax \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Leisure Services Program: \_\_\_\_\_

Date(s) of Program: \_\_\_\_\_

**PARENT AUTHORIZATION FOR THE DEPARTMENT OF HUMAN & LEISURE SERVICES OF THE TOWN OF WEST HARTFORD TO ADMINISTER EPINEPHRINE INJECTION (Part I and Part II must be completed before a child can participate in programs.)**

**PART I (To be completed by parent or guardian)**

I, \_\_\_\_\_, parent/guardian (circle one) of \_\_\_\_\_, hereby give permission to any employee, contractor, or volunteer working for, or associated with the Department of Human & Leisure Services of the Town of West Hartford to assist in the administration of epinephrine injection(s) to

\_\_\_\_\_ ONLY through the use of a pre-measured auto-injector (ie. Epi-Pen) as directed by the physician in PART II below.

In giving permission to the Department of Human & Leisure Services to administer epinephrine injection(s), I hereby agree to the following:

1. I agree to indemnify, defend and hold harmless the Town of West Hartford, the West Hartford Board of Education, their officials, officers, employees, contractors, agents and/or volunteers from any liability whatsoever for any act or omission concerning the administration of the epinephrine injection to the child listed above including, but not limited to the issues addressed in the following paragraphs.
2. I am aware that my child may be in the care of an individual with no medical training, and I understand that the injection could be administered incorrectly or may not be administered when medically appropriate. I assume the risk of delegating this responsibility to an individual who is not medically trained.
3. I understand and assume the risk that in the event that Part II of this form indicates that my child is competent and able to self-administer, my child will be permitted to carry the Epi-Pen throughout the program and will be free to determine whether to administer the Epi-pen without direction or supervision by Leisure Services staff.
4. It is my duty to provide the Epi-Pen every time my child attends a program sponsored by the Department of Human & Leisure Services. If my child is not competent and able to self-administer, the Epi-Pen will be provided to the adult in charge in a secure container. The Epi-Pen will not be stored overnight by the Department of Leisure Services.
5. It is my duty to insure the medication is labeled properly and has not expired.
6. It is my duty to insure the Epi-Pen is functioning properly and does not need replacement.
7. I understand that only premeasured doses of epinephrine will be given. I understand that if the physician orders include a repeat of Epi-Pen injection, then two Epi-Pens must be supplied. I also understand that if the physician's orders change, I will provide Leisure Services with an updated replacement for this form.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

Leisure Services Program: \_\_\_\_\_

Date(s) of Program: \_\_\_\_\_

**PART II (To be completed by physician)**

\_\_\_\_\_, residing at \_\_\_\_\_  
Patient/Child

and born on \_\_\_\_\_, is to receive \_\_\_\_\_  
Name of Medication

Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Reason for prescribing: \_\_\_\_\_

The Epi-Pen injection will be given immediately after report of exposure to (indicate allergan and type of exposure, e.g., ingestion, skin contact, or inhalation):

Side effects to watch for:

Special instructions:

Is patient competent and able to self-administer? Yes/No (circle one)

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date

Printed Name of M.D. \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_



**TOWN OF WEST HARTFORD, CONNECTICUT  
DEPARTMENT OF HUMAN AND LEISURE SERVICES  
SPECIAL NEEDS PROGRAM**

**Request for Administration of over-the-counter (OTC) Medication(s)  
By Beachland Adventures Camp Nurse 2016**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_,  
give the Camp Nurse permission for the following (please check):

- \_\_\_\_\_ **Administer Tylenol** or generic equivalent for the following circumstances (i.e. headache, cramps, muscle aches, etc). Camp Nurse will stock this pain relief product.
- \_\_\_\_\_ **Administer Ibuprofen** or generic equivalent for the following circumstances (i.e. headache, cramps, muscle aches, etc). The Camp Nurse will stock this pain relief product.
- \_\_\_\_\_ **Administer Benadryl** or generic equivalent for bee stings, respiratory distress, allergic reaction. This will be stocked by the Camp Nurse.
- \_\_\_\_\_ **Application of antibiotic** ointment such as Neosporin or Bacitracin or a generic equivalent. This will be stocked by the Camp Nurse.
- \_\_\_\_\_ **Application of anti-itch** cream such as Calamine Lotion or a generic equivalent. This will be stocked by the Camp Nurse.
- \_\_\_\_\_ **Application of sunscreen** (to be provided by family).

**You may withdraw your permission at any time by speaking with the Camp Nurse and submitting a note with your signature.**

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**Notes to Nurse:**

---

---

---

---

---

\*Please provide contact information below and indicate your preferred method of communication if the Camp Nurse has concerns or questions:

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone #1: \_\_\_\_\_ Cell Phone #2: \_\_\_\_\_

Home e-mail: \_\_\_\_\_ Work e-mail: \_\_\_\_\_



**TOWN OF WEST HARTFORD, CT**  
**DEPARTMENT OF HUMAN AND LEISURE SERVICES**  
**SPECIAL NEEDS PROGRAM**

**Authorization for the Administration of Prescription Medicine(s) by "Beachland Adventures" Camp Nurse**

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse to administer medications. Medication must be in pharmacy prepared containers and labeled with name of child, strength, dosage, frequency, physician's or dentist's name and date of original prescription.

Physician or Dentist's Order

Name of Student \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Town/City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Condition for which drug is being administered during camp \_\_\_\_\_

Drug: Name, dose and method of administration \_\_\_\_\_

Time of administration \_\_\_\_\_

Length of time during which medication shall be administered \_\_\_\_\_ to \_\_\_\_\_  
Date Date

Relevant side effects and management: \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_ If Yes, DEA Number \_\_\_\_\_

Name of Physician/Dentist (please print) \_\_\_\_\_ Date \_\_\_\_\_

Address of Physician/Dentist \_\_\_\_\_ City \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Signature of Physician/Dentist \_\_\_\_\_

Nurse \_\_\_\_\_ Date \_\_\_\_\_

Permission of Parent or Guardian for Administration of Medication

I hereby request that the above medication, ordered by the physician/dentist for my child \_\_\_\_\_, be administered by the camp nurse at "Beachland Adventures" Special Needs Camp. I understand that I must supply the camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist and will provide no more than a 38 day supply of said medication. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of camp.

Name of Parent/Guardian (please print) \_\_\_\_\_ Date \_\_\_\_\_

Street Address of Parent/Guardian \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**TOWN OF WEST HARTFORD, CT  
DEPARTMENT OF HUMAN AND LEISURE SERVICES,  
SPECIAL NEEDS PROGRAM**

**BEACHLAND PARENT SWIMMING ASSESSMENT  
2016**

*Please note that Beachland Adventures staff are required to swim and play in the pool with campers. Beachland Adventures staff are expected to be within arm's length of their campers unless you indicate that campers may have more independence on the form below.*

**Please check as appropriate:**

- ☐ My child is a swimmer. If my child passes the swim test administered by the pool lifeguards, he/she may swim in the entire pool and staff do not need to be within "arms reach". \*Beachland Adventures staff are still required to be in the pool and monitoring their camper closely at all times.
- ☐ My child is a swimmer and may utilize the entire pool with a staff member "within arms reach" at all times.
- ☐ My child is a non-swimmer and should remain in the shallow end of the pool.
- ☐ I want my child to wear a life jacket in the pool. Lifejacket must be Coast Guard approved Type I, II or III. (Parents provide to ensure correct size; label with camper's name.)
- ☐ I prefer that my child only use the spray pad (Beachland Park)
- ☐ I do not want my child to swim. Camp staff may offer alternate activities.
- ☐ My child is impulsive near water and may not recognize potential danger.

---

**Signature of Parent/Guardian**

---

**Date**

**Please send a towel & bathing suit daily. An extra t-Shirt, brimmed hat and sunglasses should be sent for sun-sensitive campers and please send sunscreen with the camper's name clearly marked on the container. If child has occasional toileting accidents, please send an extra swimsuit, shorts & underwear in separate plastic bag in backpack. Send swim diapers if needed. LABEL EVERYTHING!**

**TOWN OF WEST HARTFORD, CT  
DEPARTMENT OF HUMAN AND LEISURE SERVICES  
SPECIAL NEEDS PROGRAM**

**“PICK-UP AUTHORIZATION” 2016  
For Beachland Adventures, Camp Bookends,  
Escapades at Elmwood, and Mainstream Camp Programs**

The following individual(s) will pick up my child, \_\_\_\_\_,  
at the end of the camp day. *Please enter YOUR name first if you are providing  
transportation on most days.* Enter secondary name for any other person authorized to  
transport your child.

#1

_____ <b>Name</b>	_____ <b>Relationship</b>	_____
_____ <b>Home Phone</b>	_____ <b>Work Phone</b>	_____ <b>Cell Phone</b>

#2

_____ <b>Name</b>	_____ <b>Relationship</b>	_____
_____ <b>Home Phone</b>	_____ <b>Work Phone</b>	_____ <b>Cell Phone</b>

#3

_____ <b>Name</b>	_____ <b>Relationship</b>	_____
_____ <b>Home Phone</b>	_____ <b>Work Phone</b>	_____ <b>Cell Phone</b>

**I understand that I must notify the Camp Director or Special Needs Program staff  
IN WRITING if there is to be any change to this pick-up authorization.**

**Signed:**

\_\_\_\_\_  
**Parent/Guardian**

\_\_\_\_\_  
**Date**

<p><b>IMPORTANT!</b> No child will be released to anyone other than the above named individuals without prior written notice from parent/guardian.</p>
--

*Promptness is required.*

## PHOTO PERMISSION SLIP

From time to time we take pictures during camp activities. We would like your permission to use these pictures on our website, print materials, Facebook page, and/or our end of season talent/slide show. Pictures would be selected to highlight fun activities during the camp day. We won't reference your child by name or provide any specific information regarding your child. The pictures will only be used by the Town of West Hartford Special Needs Program to show the many ways our campers are enjoying their summer.

*Please take a moment to let us know your preferences regarding our use of photos of your children:*

\_\_\_\_\_ YES. I grant permission to use photos of my child on the Special Needs Program website, brochure, Facebook page, bulletin boards, and /or newsletters.

-OR-

\_\_\_\_\_ NO. Please do NOT take or use any photos of my child.

Child(ren)'s Name(s) (PLEASE PRINT):

---

---

---

Parent/Guardian's Name (PLEASE PRINT):

---

Parent/Guardian's Signature:

---

Date: \_\_\_\_\_

For questions or concerns about this form, contact Victoria Branning, Special Needs Coordinator, at 860-561-8173 or [victoria.branning@westhartfordct.gov](mailto:victoria.branning@westhartfordct.gov).

**TOWN OF WEST HARTFORD, CONNECTICUT  
DEPARTMENT OF HUMAN AND LEISURE SERVICES  
SPECIAL NEEDS PROGRAM SUMMER CAMPS**

**2016  
BEHAVIORAL COMPLIANCE STATEMENT**

The Special Needs Program, a division of the Department of Human & Leisure Services, offers diverse recreational opportunities for youngsters during the summer months. The Beachland Adventures provides 1:1 aides and Escapades at Elmwood provides 1:3 staff/camper ratio to support the children and ensure safety. Staff from the Special Needs Program also assist in the supervision of children who have been mainstreamed into other camp programs.

It is the intent of the Special Needs Program to provide a fun, memorable camp experience with SAFETY BEING PARAMOUNT. This includes the provision of an atmosphere in which children and staff can share recreational time without fear of injury or harm. It is important that the general public utilizing Town facilities also be provided with the same safeguards.

To this end, parents/guardians are requested to sign below to indicate their understanding of rules regarding the behavior of campers. Any acts of aggression, whether physical or verbal, will not be tolerated. If a camper aggresses to staff, fellow campers, or the general public or is in danger of harming himself/herself, the parent/guardian will be notified and the child will be removed from camp. There will be no refund for the session in which the child is registered at the time of the behavioral incident but a full refund will be made for registered sessions thereafter.

The Special Needs Program provides diverse, outdoor camp experiences to children with a variety of special needs but it is NOT a behavioral modification or specialty program. Children requiring a more structured camp experience may seek information regarding other programs from the Special Needs Coordinator in the attempts to best meet those needs. Thank you for acknowledging your understanding of this behavior policy by affixing your signature below. PLEASE RETURN ONE COPY and keep the other for your reference.

CAMPER NAME: \_\_\_\_\_ Date \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

PARENT/GUARDIAN PRINT NAME: \_\_\_\_\_

**TOWN OF WEST HARTFORD, CONNECTICUT  
DEPARTMENT OF HUMAN AND LEISURE SERVICES  
SPECIAL NEEDS PROGRAM SUMMER CAMPS**

**2016  
BEHAVIORAL COMPLIANCE STATEMENT**

The Special Needs Program, a division of the Department of Human & Leisure Services, offers diverse recreational opportunities for youngsters during the summer months. The Beachland Adventures provides 1:1 aides and Escapades at Elmwood provides 1:3 staff/camper ratio to support the children and ensure safety. Staff from the Special Needs Program also assist in the supervision of children who have been mainstreamed into other camp programs.

It is the intent of the Special Needs Program to provide a fun, memorable camp experience with SAFETY BEING PARAMOUNT. This includes the provision of an atmosphere in which children and staff can share recreational time without fear of injury or harm. It is important that the general public utilizing Town facilities also be provided with the same safeguards.

To this end, parents/guardians are requested to sign below to indicate their understanding of rules regarding the behavior of campers. Any acts of aggression, whether physical or verbal, will not be tolerated. If a camper aggresses to staff, fellow campers, or the general public or is in danger of harming himself/herself, the parent/guardian will be notified and the child will be removed from camp. There will be no refund for the session in which the child is registered at the time of the behavioral incident but a full refund will be made for registered sessions thereafter.

The Special Needs Program provides diverse, outdoor camp experiences to children with a variety of special needs but it is NOT a behavioral modification or specialty program. Children requiring a more structured camp experience may seek information regarding other programs from the Special Needs Coordinator in the attempts to best meet those needs. Thank you for acknowledging your understanding of this behavior policy by affixing your signature below. PLEASE RETURN ONE COPY and keep the other for your reference.

CAMPER NAME: \_\_\_\_\_ Date \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

PARENT/GUARDIAN PRINT NAME: \_\_\_\_\_



**WEST HARTFORD LEISURE SERVICES**  
**SAFETY AND EMERGENCY CONTACT INFORMATION FORM**  
**TO COMPLETE THE ENROLLMENT PROCESS FOR YOUR CHILD,**  
**YOU MUST COMPLETE, SIGN AND RETURN THIS FORM BEFORE THE CLASS BEGINS**  
**Your child will not be allowed to attend without a completed form.**

Program Name \_\_\_\_\_ Program # \_\_\_\_\_

**PARTICIPANT'S Name** \_\_\_\_\_

Address \_\_\_\_\_

**Parent/ Guardian's Name** \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Family Email address (Please print clearly) \_\_\_\_\_

.....  
**Emergency Contact** (Person to call if unable to contact parent/guardian):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

.....  
Does your child have any known allergies or have any known illnesses or physical limitations, etc. Please list and describe:

\_\_\_\_\_

List Medications \_\_\_\_\_

Has child been prescribed an Epi-pen? Yes \_\_\_\_\_ (if yes, an Epi-pen form will be sent to you) No \_\_\_\_\_

Family Doctor's Name \_\_\_\_\_ Doctor's Phone Number \_\_\_\_\_

.....  
**Please read each statement below and if you understand and agree to each statement *WRITE YOUR INITIALS* in the space next to the paragraph to signify your understanding and agreement.**

\_\_\_\_\_ In the event my child needs emergency hospital or medical care while participating in this West Hartford Leisure Services Program and there is no time for me to be contacted and/or I cannot be reached, my hospital preference is:

**Hospital Name and Address** \_\_\_\_\_

\_\_\_\_\_ However, if circumstances are such that it is deemed necessary to admit elsewhere, permission is hereby granted.

\_\_\_\_\_ In the event my child needs emergency medical care while in this West Hartford Leisure Services Program, I hereby give permission for the hospital to give such emergency treatment as is considered necessary or desirable by medical judgment, including administration of anesthesia.

\_\_\_\_\_ In the event that my child needs to be transported by an ambulance, I give my permission for such transportation and I agree to assume all expenses incurred by said transportation.

\_\_\_\_\_ I agree to assume all medical expenses incurred by my child while participating in this West Hartford Leisure Services Program.

\_\_\_\_\_ I realize that as with any physical activity there is a possible risk of accidental injury to my child while participating in this West Hartford Leisure Services Program. I agree to assume the risk of any injury which my child might suffer while involved in the West Hartford Leisure Services Program and will not hold the Town of West Hartford or its instructors liable for any injuries which my child may suffer while participating in this West Hartford Leisure Services Program.

\_\_\_\_\_ **FIELD TRIPS:** I hereby give my permission for my child to go on the field trips scheduled for his/her particular camp program. The exact schedule will be provided to me at the beginning of the camp session. If I do not wish my child to attend the field trip, I understand that I will need to make other arrangements for my child on that day.

**I understand that this document may be transmitted to the Town and/or retained in electronic form. By executing this document I acknowledge and agree that a copy hereof shall be afforded full legal effect as if it was the original.**

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Complete Form and send to appropriate facility:**

**Customer Service Town Hall**  
**Elmwood Community Center**  
**Veterans Skating Rink**  
**Westmoor Park**

Email: [Leisureservices@westhartford.org](mailto:Leisureservices@westhartford.org)  
Email: [Ecc@westhartford.org](mailto:Ecc@westhartford.org)  
Email: [vmsr@westhartford.org](mailto:vmsr@westhartford.org)  
Email: [Westmoor1@westhartford.org](mailto:Westmoor1@westhartford.org)

FAX 860-561-7519  
FAX 860-561-8161  
FAX 860-521-1573  
FAX 860-236-3815